INLAND COUNTIES EMERGENCY MEDICAL AGENCY
Serving San Bernardino, Inyo, and Mono Counties
1425 South "D" Street
SAN BERNARDINO, CA 92415-0060
909-388-5823 FAX: 909-388-5825

SPECIALTY OR EMT OPTIONAL SCOPE PROGRAM APPLICATION

I. PROVIDER INFORMATION

A. Provider Name:_____

B. Address:_____
Number & Street City State Zip

II. ADMINISTRATION

A. Name of proposed Medical Director:_____

Phone Number:_____Email:_____

B. Name of proposed Coordinator & Title:_____

Phone Number:_____Email:_____

III. PROGRAM DETAILS

SUBMIT THE FOLLOWING FOR PROGRAM REVIEW:

☐ Completed original application
☐ Copy of proposed program which shall include:
- Demonstration of Need for program approval.
- Description when the program will operate (special events, 24/7).
- Description how employees will be trained and provide a list of those employees. ICEMA must be notified in the event of any changes.
- Does program require deviations from the Standard Drug and Equipment List? Provide detailed list and how equipment will be transported and stored.
- Overview of the quality assurance/quality improvement program and process for reporting.
- Description of how the program will interface with the EMS system and 9-1-1.
- Description of how the program will be implemented.

Additional information may be requested after program is reviewed.

Completed by_____
(Please print)

Signature:_____Date:_____

ICEMA Use Only

Date letter received:_____All requirements verified:_____

Approved by:_____Date: _____